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No. 02-469

IN THE
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ of Certiorari To The United States Court of Appeals for the Ninth Circuit

BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF RESPONDENT

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BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF RESPONDENT

INTEREST OF *AMICUS CURIAE*[1]

AARP is a nonprofit membership organization of approximately 35 million persons age 50 or older, working or retired, that is dedicated to addressing the needs and interests of older Americans. More than 45% of AARP's members are working. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens.[2] In its

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[1] No counsel for any party authored any portion of this brief. No persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

[2] As part of its advocacy efforts to ensure, to the greatest extent possible, that participants receive the benefit of ERISA's protections, AARP has participated as *amicus curiae* in cases concerning ERISA's benefit claims

efforts to promote independence, AARP works to foster the economic security of individuals as they age by attempting to ensure the availability, security, equity, and adequacy of public and private pension, health, disability and other employee benefits.

AARP's members and other participants in private employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights. 29 U.S.C. § 1001 *et seq*. Because the quality of their lives depends heavily upon the security and amount of their pension, health, disability and other employee benefits, ERISA's protections, and the ability to enforce those protections, are of vital concern to older workers and retirees.

In order to ensure that they are receiving the benefits to which they are entitled, AARP members and other older persons must be able to successfully have access to, and resolve benefits disputes through, ERISA's claims procedure. In particular, these participants must know what the burden of production is for all parties, the weight their evidence will receive, and that they will receive all necessary information so that they can provide competent evidence of their claim and rebut evidence relied upon by the plan. If a plan does not provide the participant with the detailed reasons for its benefit denial as required under ERISA's claims procedure, participants cannot adequately protect their claims to benefits, which may spell the difference between independence and impoverishment in their old age.

(continued...)
process, *e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154 (9th Cir. 2001); *Juliano v. Health Maintenance Organization of New Jersey d/b/a U.S. Healthcare*, 221 F.3d 279 (2d Cir. 2000); as well as numerous other ERISA cases. *See, e.g., Rush-Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Pegram v. Herdrich*, 530 U.S. 211 (2000); *Varity Corp. v. Howe*, 516 U.S. 489 (1996).

AARP has a substantial interest in the resolution of the issues presented in this appeal. These issues have a direct and vital bearing on the ability of AARP members and other plan participants to have benefit claims fully and fairly reviewed as required by ERISA. Accordingly, AARP respectfully submits this brief *amicus curiae*.

SUMMARY OF ARGUMENT

At bottom, this case is about the fiduciary's conduct in reviewing the evidence the participant submitted to the plan to prove his right to receive disability benefits.[3/] Even if the plan provides the fiduciary with unfettered discretion, that discretion does not permit the fiduciary to ignore the participant's evidence without giving a rational reason for so doing. Here, the fiduciary gave no reason for rejecting the opinions of the treating physicians and the employer's human resource representative. ERISA and its claims regulation require more. ERISA § 503, 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1 (2003).

[3/] In this case, because the plan contends that it has no duty to provide the participant with the reasons it gave the treating physicians' opinions no weight, *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002), the Court need not decide whether the treating physician rule should be adopted as a substantive rule.

ARGUMENT

I. DETERMINING THE APPROPRIATE STANDARD OF REVIEW WHEN REVIEWING A BENEFIT CLAIMS DENIAL MAY REQUIRE A COURT TO LOOK BEYOND THE TERMS OF THE PLAN.

A. *Firestone* Recognized That a Denial of a Claim for Benefits Is Presumptively Reviewed under the *De Novo* Standard.

Relying on trust law, the Court held that "a denial of benefits challenged under 29 U.S.C. § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-12, 115 (1989). *De novo* review is always the standard of review unless discretion is clearly and unambiguously reserved. *See Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2170 (2002). ERISA does not provide by its terms, either directly or indirectly, for a deferential standard of judicial review of benefit denials. *Id.*

In *Firestone*, the Court went on to comment that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (citing RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)). In *Rush Prudential*, the Court flagged the open question now presented in this case of whether a plan provision providing for unfettered discretion in benefit determinations guarantees truly deferential review, especially "when the judicial eye is peeled for conflict of interest." 122 S. Ct. at 2169 n.15.

B. If the Fiduciary Acts from an Improper Motive, Then A Court Should Review the Plan Administrator's Decision *De Novo* Even If Plan Terms Provide for Unfettered Discretion.

The simple answer to the question raised by the Court in *Rush Prudential* is that trust law recognizes specific situations where even unfettered discretion is circumscribed so that a court will review a fiduciary's decision *de novo*. A conflict of interest is one of many factors in determining both whether a fiduciary has an improper motive or abused its discretion. RESTATEMENT (SECOND) OF TRUSTS § 187 cmts. d & g (1959).

RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) provides specific situations when a fiduciary's discretion may be circumscribed. Among situations which may circumscribe a fiduciary's exercise of discretionary power granted by the terms of the trust are provisions in the law overriding plan terms; when the fiduciary acts dishonestly or with an improper, even though not dishonest, motive; when the fiduciary fails to use its judgment, breaches its fiduciary duty; or acts beyond the bounds of a reasonable judgment. *Id.* at cmts. a, d & i.

If the fiduciary has a conflict, the conflict should be considered in determining whether it has an improper motive. RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. g (1959). The Restatement of Trusts defines improper motive as one where the fiduciary "acts from a motive other than to further the purposes of the trust." *Id.* Such a motive may not necessarily be dishonest, but may be done out of "spite, prejudice or to further some other interest of his own or a person other than the beneficiary." *Id.* Where a fiduciary acts from an improper motive, a court will review its decision *de novo*.

Although a conflict may arise from various circumstances, the most common circumstance in an ERISA benefit claims denial case is where the insurer responsible for the benefit denial is both the funding source and the plan administrator. Most courts have found this circumstance to be an inherent conflict of interest in ERISA benefit claims denial cases. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 384 (3d Cir. 2000) (collecting cases). *See also, e.g., Lain v. UNUM Life Ins. Co.*, 279 F.3d 337 (5th Cir. 2002) (insurer's inherent, institutional conflict of interest infused into its employees by providing substantial financial bonus incentives); *Fox v. Fox*, 167 F.3d 880 (4th Cir. 1999) (former husband who also was administrator and refused to qualify former wife's qualified domestic relations order resulted in conflict).

However, the Ninth Circuit has recognized that under trust law such a conflict without more does not require a court to review the fiduciary's decision under the *de novo* standard.[4/] The Ninth Circuit employs a significantly more stringent standard: If the participant can show there is a conflict and produce evidence that tends to show that the conflict infected the decision to pay benefits, the burden then shifts to the fiduciary to show that its motive was not improper – that is, that its decision was made for reasons other than merely to avoid paying benefits. RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. g (1959). If the fiduciary cannot rebut the participant's showing, then the court should find that there is an improper motive – a failure to further the purposes of the trust to properly pay benefits to participants – and review the

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[4/] In some circuits, if the participant can show a conflict, the court will review the fiduciary's decision with heightened scrutiny. Depending on the extent of the conflict, the review will be more or less deferential. *See Pitman v. Blue Cross*, 217 F.3d 1291, 1295 (3d Cir. 2000) (finding that the greater the potential conflict, the greater the court's scrutiny of the benefit denial decision). Neither the plan nor the participant know what their burden of going forward is, the weight their evidence will receive, or the degree of scrutiny the benefit denial will receive. Clearly, such an approach is highly subjective.

fiduciary's decision *de novo*. *See Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556 (11th Cir. 1990) (shifting the burden to fiduciary to show that it is operating exclusively in the interests of the participants). This standard for determining whether there is an improper motive is consistent with the Restatement of Trusts, *see* RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. g (1959), and should be adopted by this Court.

II. A COURT MUST REVIEW ALL THE EVIDENCE IN THE RECORD TO ASSESS WHETHER THE PLAN CONSIDERED ALL SUCH EVIDENCE AND PROVIDED REASONS FOR DISCOUNTING EVIDENCE IT DID NOT RELY UPON TO DETERMINE IMPROPER MOTIVE.

A. The Evidence A Court Must Review to Determine Whether There Is Improper Motive Will Be Case Specific.

In looking at the evidence tending to show improper motive, participants will marshal, and courts will consider, all relevant evidence. Material probative evidence may include: a plan's inconsistent statements or actions, *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 799 (9th Cir. 1997); *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d at 1569; the failure of the plan to respond to evidence the participant submitted; insufficiency in the plan administrator's reasons, *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 977 (9th Cir. 1999); and procedural irregularities in the processing of the participant's claim. *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1110 (9th Cir. 1999); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998). A fiduciary may be able to rebut the participant's proof by showing that its decision was a benefit to all of the plan's participants. *See Yochum v. Barnett Banks, Inc.*, 234 F.3d 541, 546 (11th Cir. 2000) (fiduciary may justify decision on the ground that it benefits the class of all participants and beneficiaries). For example, the fiduciary

could show that its decision reflects a consistent interpretation of the plan and the plan denied benefit claims for similarly situated participants, resulting in a decision to avoid depletion of plan resources. *See, e.g., Pompano v. Michael Schiavone & Sons, Inc.*, 680 F.2d 911 (2d Cir. 1981) (trustees' decision not to grant discretionary lump sum payment benefitted participants by maintaining plan's financial integrity).

In this case, the Ninth Circuit considered, among other evidence, the plan's failure to deal with or respond to the treating physician's opinion. The court construed the failure to respond to the treating physician's opinion along with other evidence, including Black & Decker's own human resource representative, to indicate an improper motive to deny benefits.

In response to the Ninth Circuit's admonition that it could have produced sound reasons for its decision, the plan contended before the Ninth Circuit that it had "no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative." *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002). The plan's response is extremely disturbing and disingenuous, given ERISA's requirements.

Under this plan's viewpoint, it would never have to look at any information provided by the participant if it was favorable to the participant. This viewpoint leads inexorably to the conclusion that a plan could grant or deny benefits totally at will. This is no standard at all.

B. In Order to Ensure That Participants Will Receive a Full And Fair Review, ERISA's Claims Procedure Requires That The Plan Provide The Participant With Specific Reasons For Denying The Claim And Not Relying Upon Evidence Favorable to The Participant.

Among the safeguards that Congress enacted was a claims procedure to resolve disputes over benefit claims. ERISA § 503, 29 U.S.C. § 1133. Section 503 provides that when a participant's claim for benefits has been denied, a benefit plan shall provide adequate written notice to the participant, setting forth the specific reasons for the denial, written in a manner to be understood by the participant.[5] *Id.* Section 503 also states that the plan shall provide the participant with a reasonable opportunity for a full and fair review of the benefit denial. 29 U.S.C. § 1133. The claims procedure provides that the plan must provide specific information to participants if their benefit claims are denied. 29 C.F.R. § 2560.503-1(f) (1977).

In issuing its regulation interpreting Section 503, the Department of Labor unambiguously furthered Congress' intention to furnish participants with procedural safeguards for their benefits. "[T]he rules [for the claims procedure] are designed to insure that plan participants and beneficiaries have their claims for benefits handled by their plans in a fair way." Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (May 27, 1977).[6] This claims procedure

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[5] Section 503's disclosure requirements are consistent with ERISA's objective of providing full disclosure to participants. ERISA § 2(a), 29 U.S.C. § 1001(a). Congress realized that only full disclosure would enable participants to vindicate their rights. *See* S. REP. NO. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4863.

[6] *Nord* was decided under the 1977 regulations. In 2000, revised regulations were issued, maintaining the protections under the 1977 regulations and, in many instances, conferring additional safeguards. *See* Minimum Requirements for Benefit Claims Procedures, 65 Fed. Reg. 70246

regulation requires that the initial notice of a claims denial contain: (1) the specific reason(s) for the denial; (2) specific reference to pertinent plan provisions upon which the denial is based; (3) a description of additional materials or information necessary for the participant to perfect the claim and an explanation of the reason such material or information is necessary; and (4) appropriate information as to the steps to be taken if the participant desires to submit the claim for review. 29 C.F.R. § 2560.503-1(f) (1977).[7/] The regulation also requires that a plan have an internal review procedure, which allows participants or their representative to request review, review pertinent documents, and submit comments in writing. 29 C.F.R. § 2560.503-1(g) (1977).[8/]

The purpose of these regulations is to provide participants with the information needed for a meaningful review of their denial of benefits: an adequate explanation of the denial of benefits, a record of what evidence the plan relied upon in denying the benefit, an opportunity to address the accuracy and reliability of that evidence, and an opportunity to have the plan consider the participants' evidence prior to reaching its decision. *Grossmuller v. International Union*, 715 F.2d 853, 858 n.5 (3d Cir. 1983). The reasons for the required information are to ensure participants that their claims are handled fairly, Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (May 27, 1977); to provide participants with the information needed for a meaningful review of their denial of benefits so that they can address the determinative issues, *see Grossmuller*, 715 F.2d at 857-59; to reduce frivolous appeals, *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980); and to enable participants to prepare adequately for further administrative review and appeal to

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(Nov. 21, 2000) (codified at 29 C.F.R. pt. 2560).

[7/] These requirements are found in the 2000 regulations under 29 C.F.R. § 2560.503-1(g) (2000).

[8/] These requirements are found in the 2000 regulations under 29 C.F.R. § 2560.503-1(h) (2000).

the federal courts if necessary. *See Richardson v. Central States, Southeast & Southwest Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981); *accord*, *Halpin v. Grainger, Inc.*, 962 F.2d 685, 689 (7th Cir. 1992). These requirements also ensure that when participants appeal their denials to the plan administrator, they will be able to address the determinative issues. Thus, these requirements "enable[] a participant both to appreciate the fatal inadequacy of his claim as it stands and to gain a meaningful review by knowing with what to supplement the record." *Wolfe v. J.C. Penney Co.*, 710 F.2d 388, 392 (7th Cir. 1983).

"In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Only a plan knows the reasons for the benefit denial, the information which participants need to perfect their claims, and the information and documents upon which the plan relied to make its decision. Participants do not have this knowledge. Without an exchange of information, the trustees will not have had the opportunity to fully consider the participants' arguments and evidence. Nor will they have had the opportunity to refine the issues. In addition, trustees will have the opportunity to ensure that they have treated benefit claims consistently and minimize the costs of settlement. *Amato*, 618 F.2d at 568. A plan must meet these minimum requirements of the regulation so that participants receive full and fair review of their claim for benefits.

In this case, the plan's failure to provide the reasons it rejected the opinions of the treating physicians and human resource representative should be enough for any court to find improper motive.

C. The Treating Physician's Opinion Should Be Accorded Significant Weight Unless the Plan Provides Specific Legitimate Reasons for Not Doing So.

The treating physician's opinion will be one of the most important pieces of evidence that the participant submits to the plan in support of the claim for benefits. In order to prove the participant's entitlement to disability pension, health or disability benefits, the treating physician must provide the plan with the reasons he or she concludes that the participant needs a certain medical treatment or makes a diagnosis which draws conclusions about the ability of the participant to work. Given the regulatory requirement that a plan provide the reasons a benefit claim is denied, it certainly would seem suspicious to a court if a plan provides no response to this crucial piece of evidence.

Under this burden shifting approach, the treating physician's opinion does not trump all other evidence, but it must be given appropriate weight. *Conley v. Pitney Bowes*, 176 F.3d 1044, 1049 (8th Cir. 1999). To determine the appropriate weight to give the treating physician's opinion, the plan must thoroughly review, consider, and analyze the treating physician's opinion. If the plan chooses not to rely upon the opinion or reject it, it must provide the participant with the reasons for so doing so that the participant may respond. The plan may reject or discount the treating physician's opinions for a myriad of reasons.[2/] *See, e.g.*, *Wallace v. Reliance Standard Life Ins. Co.*, 318 F.3d 723

[2/] Petitioner and some of its *amici* contend that the treating physician's opinion should be discounted because some treating physicians may not be objective in giving their opinions due to potential financial gain. Likewise, similar allegations have been made by participants concerning physicians who review cases for insurers and plans. *See, e.g., Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 203 U.S. App. LEXIS 937, *32 (6th Cir. 2003). The appropriate method of handling this issue is not to say "a pox on both of your houses," but to permit a party to submit evidence in the record to demonstrate that a particular physician's opinion is "tainted."

(7th Cir. 2003) (treating physician stated no longer disabled; fiduciary under no obligation to obtain additional information); *Fletcher-Merrit v. Noram Energy Corp.*, 250 F.3d 1174 (8th Cir. 2001) (treating physician's opinion not entitled to greater weight where his opinion based on opinions of non-treating doctors); *Gooden v. Provident Life & Acc. Ins. Co.*, 250 F.3d 329 (5th Cir. 2001) (treating physician's opinions were contradictory); *Heaser v. The Toro Co.*, 247 F.3d 826 (8th Cir. 2001) (treating physicians disagreed as to disability status); *cf. Newcomb v. Standard Ins. Co.*, 187 F.3d 1004 (9th Cir. 1999) (treating physicians had special expertise in diagnosis of this particular disability as compared with insurer's physician; therefore more weight was appropriate). The ultimate decision to determine whether benefits should be granted or denied still rests with the fiduciary after full consideration of all the evidence in the record. *See Crocco v. Xerox*, 956 F. Supp. 129, 138-42 (D. Conn. 1997), *aff'd*, 137 F.3d 105, 108 (2d Cir. 1998) (no full and fair review because administrator relied on third party without making an independent review of record and weighing all physicians' opinions).

Responding to the treating physician's opinions is simply the manner in which the claims process works. Not only is the failure to provide the participant with any reasons the plan is rejecting or discounting the treating physician's opinion a violation of the requirements of the claims procedure, but it also raises the issue of whether the plan fiduciary has breached its fiduciary duties by not administering the plan correctly. *See Friedrich*, 181 F.3d 1105 at 1110 (the presence of procedural irregularities in the initial claims process or the appeals process can demonstrate that a breach of fiduciary duty may have taken place).

Ignoring the treating physician's opinion here is evidence that would tend to show that the decision to deny benefits was made from an improper motive. If the plan does not rebut the evidence tending to show that there was an improper motive by showing that the same decision would have been made regardless of the conflict or improper motive

– like the plan's failure to do so here – then the court should review to decision to deny benefits *de novo*.

CONCLUSION

For the foregoing reasons, AARP urges the Court to affirm the Ninth Circuit's decision.

March 28, 2003

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